IN THE

Supreme Court of the United States

OCTOBER TERM, 1975

No. 75-1690

T.M. "JIM" Parham, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W.T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J.L. AND J.R., Minors, Individually and as representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA

BRIEF FOR APPELLEES

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OPINION BELOW

The opinion of the district court is reported at 412 F. Supp. 112. The order of the district court denying appellants' motion to stay is reported at 412 F. Supp. 141.

JURISDICTION

The jurisdictional requisites are adequately set forth in the Brief of Appellants.

QUESTIONS PRESENTED

1. When a parent or guardian requests that the state (through the admitting physician at a state mental hospital) make a decision to admit and detain their child in a state mental health facility, there is sufficient "state action," including subsequent action by the state mental health facility, to implicate the Due Process Clause of the Fourteenth Amendment.

2. Whether a statute which allows the state upon application of a parent or guardian to admit and detain a child in a state mental institution for an indefinite period of time without any prior procedural safeguards is violative of the Due Process Clause of the Fourteenth Amendment, and is therefore unconstitutional.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The constitutional and statutory provisions involved are adequately set forth in the Brief of Appellants.

STATEMENT OF THE CASE

On October 24, 1975, two minors, J.L. and J.R., filed a class action complaint pursuant to 28 U.S.C. §1343(3) and 42 U.S.C. §1983 in the United States District Court for the Middle District of Georgia on behalf of "all persons younger than 18 years of age now or hereafter received by any defendant for observation and diagnosis and/or detained for care and treatment at any 'facility' within the State of Georgia pursuant to 1969 Georgia Code Annotated §88-503.1" [A. 49] The plaintiffs requested that the district court declare Ga. Code §88-503.1 unconstitutional as violating the due process clause of the Fourteenth Amendment, and to enjoin its enforcement.

A parent or guardian, pursuant to Ga. Code §88-503.1(a), can request that the state make a decision to admit and detain a child in a state mental health facility for observation and diagnosis for an unlimited period of time. If found to have evidence of mental illness and to be suitable for treatment, formal detention can exist for an indefinite period of time. Children placed in this fashion are designated as "voluntary" patients by the statute. J.L. and J.R. had each been detained in excess of five years.

On November 15, 1975, a three judge court was convened pursuant to 28 U.S.C. §§2281, 2284, and heard oral argument on the legal issues. On November 17, 1975, the class as defined above was certified by the district court. Oral testimony was taken by deposition of 23 expert and lay witnesses. The court visited two state mental institutions and reviewed extensive exhibits.

On February 26, 1976, the court issued its unanimous opinion. The court found that applications for hospital admission are in practice made either by parents or county welfare departments as guardians. It then noted a "constellation of disturbances" involving both the child and the parent whenever the parent requests that the state institutionalize the child. Despite the good intentions of many parents, the court concluded that there are a lot of people who still treat mental hospitals as "dumping grounds." 412 F. Supp. at 133, 138.

The observation stage of the admission process results in children being confined or placed in a hospital "behind locked doors." The physicians who decide upon detention "like all humans are capable of erring," and thus, "psychiatrists like parents cannot be given the power to confine a child in a mental hospital without procedural safeguards." 412 F. Supp. at 138.

In practice, the minor child once committed can be released only if the hospital and parent or guardian agree. Due to the absence of alternative placements, a superintendent cannot release a child without willing and able parents; the absence of parents ready to "accept their child is unfortunately a normal situation." 412 F. Supp. at 135.

The state was made aware of these conditions by a report from a Study Commission on Mental Health Services for Children in 1973, but failed to take any action. 412 F. Supp. at 123.

The district court noted that the liberty interest of juveniles in the context of these facts was strikingly similar to the losses sustained by a juvenile in a delinquency proceeding. 412 F. Supp. at 137. The

court rejected the defendant's arguments that the parent and/or admitting physician provide adequate safeguards to prevent unwarranted institutionalization. Instead, it found the statutory scheme provided "absolutely no due process." 412 F. Supp. at 139.

The court did not prescribe the full range of procedural protections that might be required by the due process clause under these circumstances. Rather, it stated only that "traditionally due process includes the right after notice to be heard before an impartial tribunal." 412 F. Supp. at 137. The court found that there were existing state mechanisms through which juveniles could be committed to mental institutions, and which appeared to provide minimal safeguards (Juvenile Court, Court of the Ordinary).

Finally, the court was confronted with the state's admission that there were 46 children [of the approximately 150 in the class] inappropriately confined in state mental institutions, and that this unnecessary hospitalization was causing these children harm. Accordingly, the court found that the state could not continue to confine these 46 children in institutions.

The court specifically retained jurisdiction in order to monitor the progress of the state, and to provide such additional hearings or orders as might be required. 412 F. Supp. at 140.

Following the decision of the court below, the defendants appealed the judgment to this court and made application for a stay pending on appeal.[1] A stay

[1] Pending review by this Court, J.L., one of the named plaintiffs, died. The Court was informed of his death by letter in August, 1976. The death of J.L. does not moot the instant

(continued)

was denied by the lower court, [412 F. Supp. 141], but was subsequently granted by this court on April 5, 1976 [96 S.Ct. 1503]. Probable jurisdiction was noted by this Court on May 31, 1977.[2]

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action. Since this case was certified as a class action pursuant to *Fed. R. Civ. P.*, Rule 23, the mootness of the named plaintiff does not inexorably require dismissal. Rather, this case falls squarely within the *Sosna v. Iowa*, 419 U.S. 392 (1975) and *Franks v. Bowman Transportation Co.*, 424 U.S. 747 (1976) rationale discussed by the Court in *Kremens v. Bartley*, ___ U.S. ___, 97 S.Ct. 1709 (1977). As in *Sosna*, the district court's certification of the class remains exactly the same. Mootness of the named plaintiff arises solely "due to the inexorable passage of time rather than to any change in the law," and like *Franks*, the metes and bounds of the class remain the same; the named plaintiff is simply no longer within it. *Kremens v. Bartley, supra*, slip. op. at 11. Finally, since the initial class was certified, it has not been effected by any intervening legislation or regulation. It is thus a "properly certified" class that may succeed to the adversary position of a named representative whose claim becomes moot. *Kremens v. Bartley*, citing *Board of School Comm'rs v. Jacobs*, 420 U.S. 128 (1975).

[2] While recognizing that the Statement of the Case is designed to give the Court an overall view of the circumstances of the case and is not designed to set forth arguments of law or fact, there are several assertions made by appellants in their Statement of the Case, which in the interest of presenting an objective Statement of the Case require comment here with further elaboration reserved for the Argument section.

(a) J.L. was not discharged from Central State Hospital in 1972, but he was placed on furlough at that time.

(b) J.R. had four temporary holiday visits to foster homes. These were not regular foster homes.

(c) There was substantial dispute in the trial court as to the extent of and effectiveness of alleged consideration of alternative placements prior to commitment and screening by

(continued)

SUMMARY OF ARGUMENT

The district court was correct in striking down the provision of Ga. Code §88-503.1 relating to the commitment of juveniles to the state's mental institutions because of the absence of even the most basic of the traditional due process safeguards–notice and the right to a hearing before an impartial tribunal.

The liberty interests of a juvenile are implicated in the state's involuntary incarceration of the juvenile in a state mental institution. However, in deciding whether the Georgia statute provides adequate safeguards, it is necessary to look beyond the nature of the child's interest to the potential and actual effects of institutionalization upon the child as well as to the nature and extent of the interests of both the parents and the state.

In addition to the child's interest in being free from unwarranted physical restraints by the state, which is worthy in itself of safeguards, the very nature of incarceration has numerous other damaging effects including: (1) the regimentation of institutional life which creates institutional dependence and robs the child of the very skills which are required for coping with life outside the institution; (2) the inadequacies

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community facilities prior to commitment. Even appellants' own witnesses did not agree on the extent of or effectiveness of these alleged practices.

(d) There was substantial evidence before the trial court relating to the adverse effects on plaintiffs of life within the institution, and the court visited two of these facilities and personally observed these conditions.

and inherent limitations of the institutions themselves; (3) the loss of continuity of relationships during the developmental years when such continuity is so essential; (4) the duration of the confinement, where the average length of confinement for the class as a whole was 248.6 days and for the named plaintiffs was over 5 years for each; and (5) the undeniable, long-lasting effects of the stigma of institutionalization. These effects which follow the decision to institutionalize a child emphasize the necessity for adequate protections to insure that children are not erroneously institutionalized. Certainly, good therapy demands that each of these adverse effects be increasingly minimized for even those who are subject to commitment, but due process safeguards are designed to prevent these effects altogether for those children who are not mentally ill or not in need of treatment.

Appellees readily acknowledge the importance afforded by our system to the basic rights and duties of parents in the upbringing of their children but feel that these interests must be viewed in the context of the realities surrounding the incarceration of juveniles in mental institutions. It is beyond dispute that a significant number of the families involved with state mental institutions are dysfunctional families, and thus there are inherent conflicts of interest between parents and children. Thus, even though it is certainly unfortunate and one can wish it were not so, the fact remains that in these situations the interests of family solidarity are minimal. Likewise, in those situations where the state is the "parent," the interests of family solidarity are not relevant. Finally, even in intact families, where the interests in family solidarity are

significant, the fact remains that the inherent pressures on and tensions within the family in dealing with the emotional problems of the child are often enormous and make the risks of conflicts of interest and erroneous commitment quite significant and reinforce the need for procedural safeguards. The interest of the family is not to be free of the child, but in the solidarity of the family and in assuring that needed and appropriate mental health services are provided which meet their child's therapeutic needs and which do not needlessly damage the child. Appellee does not seek to exclude the parent from a meaningful part in the commitment decision. However, in a situation fraught with uncertainty, potential conflicts of interest, emotional pressures, and institutional biases, appellees do seek to provide an impartial forum where the child's interests and the circumstances may be reviewed independent of these pressures and the presently granted absolute power of the parent and the admitting physician.

This need for impartial review is further strengthened by the inadequacies within the mental health system: (1) the tendency to institutionalize and to overemphasize pathology; (2) the failures in the admissions process to insure that all necessary information is obtained and to insure that the information used in the decision is in some way validated; (3) the lack of standards in the admissions process.

This Court need not reach the issue of what specific, additional due process safeguards might be required. The district court invalidated the Georgia statute because of the absence of even the most fundamental due process safeguards–notice and a hearing before an

impartial tribunal. The court did not feel compelled to explore the precise parameters of these protections or possible additional protections, but instead it pointed to other Georgia statutes which had not been attacked and which could be used by parents and the state to institutionalize children and left it to the Georgia General Assembly to devise alternative procedures if that body deemed them necessary.

The burden on the state of complying with existing state laws for the commitment of children is not substantial. These laws were passed a number of years ago, have been used to commit over one third of the children incarcerated in Georgia's mental hospitals since 1969, and have not proven to be unworkable or significantly burdensome.

Finally, the district court was correct in directing the state to remove 46 children from state mental institutions and place them as soon as reasonably possible in a non-institutional setting chosen by the state. By the state's own admission these 46 children needed to be in a non-institutional setting and were being harmed by continued incarceration. The district court had no other choice. When the state attempts to exercise its *parens patriae* role in confining a child in a mental institution for treatment, it may not harm the very child who is in their care for protection and treatment.

ARGUMENT

I.

WHEN A PARENT OR GUARDIAN REQUESTS THAT THE STATE (THROUGH THE ADMITTING PHYSICIAN AT A STATE MENTAL HOSPITAL) MAKE A DECISION TO ADMIT AND DETAIN THEIR CHILD IN A STATE MENTAL HEALTH FACILITY, THERE IS SUFFICIENT "STATE ACTION," INCLUDING SUBSEQUENT ACTION BY THE STATE MENTAL HEALTH FACILITY, TO IMPLICATE THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT.

By its express terms, the Fourteenth Amendment applies only to deprivations by a state, "That Amendment erects no shield against merely private activity, however . . . wrongful." *The Civil Rights Cases*, 109 U.S. 3 (1883).

The requirement of "state action" has, however, frequently been held to include ostensibly private conduct. *See, e.g., Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961); *Public Utilities Commission v. Pollak*, 343 U.S. 451 (1952). As a rule, such conduct will be designated a "state action" for purposes of the Fourteenth Amendment if the State has, "to some significant extent" *Burton, supra*, at 722, become involved in it. State involvement with ostensibly private conduct need be neither "exclusive or direct."

Before the existence of "state action" within the purview of the Fourteenth Amendment can be

determined, there must be a "shifting of facts and weighing of circumstances." *Burton, supra,* at 722. While no iron-clad test, applicable to every situation, has been formulated for the recognition of "state action," it is clear that in each case, "the crucial factor is the interplay of government and private action." *NAACP v. Alabama,* 357 U.S. 449, 463 45 (1958).

A particularized inquiry into the facts and circumstances surrounding the admission of a child to a state mental health facility in Georgia and the detention of the child after his admission under the challenged statute clearly indicates sufficient state involvement to invoke the protections of the Fourteenth Amendment.

A. Under The Challenged Statute, Placement And Detention Of A Minor In A State Mental Healt' Facility Involves Sufficient State Action To Implicate The Fourteenth Amendment.

The Georgia statutory scheme creates a vehicle whereby a child may be detained in a state mental health facility upon the application of his "parent or guardian." This detention is the result of a three-step process outlined by the statute and an analysis of this process clearly demonstrates the presence of the requisite state action.

The threshold step in the process involves the decision upon the part of the parent or guar[illegible]n to involve the state in determining their child's needs and how best to meet them, by making application to the superintendent of a state facility. In the case of the appellee J.R., this decision was made by the Georgia

Department of Family and Children's Services. There can be no dispute that this is a decision which is totally imbued with "state action."[3] *Cf. O'Connor v. Donaldson,* 422 U.S. 563 (1975); *Lynch v. Baxley,* 386 F. Supp. 378 (M.D. Ala. 1974); *Dixon v. Attorney General of Pennsylvania,* 325 F. Supp. 966 (M.D. Pa. 1971).

In the case of the appellee J.L., the decision to involve the state was made by his parents. This decision was essentially private action reflecting parental frustration[4] and not imbued with any modicum of state action.

The second step in the process which leads to the placement of a child in a state institution is clearly a crucial one which deeply involves the state. Once an application is made, the child is examined by state psychiatrists, psychologists, and social workers to determine whether or not the child shows "evidence of mental illness" and is "suitable for treatment."[5]

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[3] As the district court noted, the hospitalization of children for whom a county Department of Family and Children's Services is custodian generally results from a determination that foster parental care is unavailable or has been tried and found to be unworkable, leaving hospitalization as the only alternative. Opinion of the District Court, 412 F.Supp. at 134.

[4] Opinion of the District Court, 412 F.Supp. at 133-34.

[5] At this point, the discussion will focus on the "state action" analysis of this case where the parents are the initiators of the placement action. Since placement decisions by state or county agencies are themselves "state actions," no further state action need be found. *See, e.g., Smith v. Organization of Foster Families for Equalization and Reform,* ____ U.S. ____, 97 S.Ct. 2094 (1977); *Drummond v. Fulton County Dept. of Family and Children's Services,* 547 F.2d 835 (5th Cir. 1977) (rehearing en banc granted).

As previously noted, parents do not decide whether or not their children should be institutionalized. They merely decide whether or not to ask the state to make a decision as to institutionalization for their child. The determination as to whether or not a child is to be institutionalized is essentially made by the employees of the state's mental health system. As the director of the State's Child and Mental Health Services testified:

> The parent may come in saying, 'I can't handle it any more; do something.' And they say at the hospital or it might be the psychiatrist who says, 'I think hospitalization is indicated.' The parent would agree and that would decide it.[6]

Without this action by the state psychiatrists and employees of the state mental health system, there can be no detention of the child in the state mental health system. It is this participation by the state in the actual detention decision which transforms the essentially private decision of the parents [to involve the state in determining their child's needs and how to best meet them] into governmental action falling within the ambit of the Fourteenth Amendment. It is immaterial for "state action" purposes that the parent's decision to involve the state is a private parental one. This Court has consistently found "state action" where the initiator of challenged activity was a private individual or organization. *See, e.g., Burton, supra; Reitman v. Mulkey,* 387 U.S. 369 (1967); *Public Utilities Commission v. Pollak,* 343 U.S. 451 (1952); *Shelley v. Kraemer,* 334 U.S. 1 (1948); *Nixon v. Condon,* 286 U.S. 73 (1932).

[6] Opinion of the District Court, 412 F.Supp. at 134.

Once the state psychiatrist has determined that a child should be hospitalized, the third step in the process occurs. The parents acquiesce, and the child is then, without further inquiry, placed in a state mental institution. At this point, the interaction between the parent and the state which results in the detention of the child reaches full flower. The state, becomes the active detainer. The state now backs its decision to detain, however wrongful and unwarranted it may have been, with state facilities and funds.

At this point, the state through the statutory scheme has effected the child's detention without any procedural safeguards and has elected "to place its power, property and prestige," *Burton, supra,* at 725, behind the unreasoned private efforts to wrongfully deprive the child of his liberty.[7]

One commentator has pointed out that "at least when the battle lines are clearly drawn between parent and child—and overt state support is invoked by the parent, it makes sense to insist that this parentally-invoked state authority be held subject to the constitutional norms applicable to the police power, and that the state be required to respect children's claims to developing autonomous individuality." Indeed, "the parents' acquiescence in state intervention may itself convincingly establish the need for it."[8]

[7] *See Cooper v. Aaron,* 358 U.S. 1, 4 (1958). (There is "state action" when there is "state participation through any arrangement, management, funds or property"); *Shelley v. Kraemer,* 334 U.S. 1, 20 (1948) (state action, as that phrase is understood for purposes of the Fourteenth Amendment, refers to exertions of state power in all forms.)

[8] Burt, "Developing Constitutional Rights Of, In and For Children," 39 Law & Contemp. Prob. 118, 137-38 (1975).

Appellant fails in its attempt to analogize the state action here to the state action found to be lacking in *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974) and *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163 (1972). Both *Jackson* and *Moose Lodge* involve essentially private activities which are merely licensed by the state, and for which the state provides minimal sanctions and services. This case involves an essentially state activity, *i.e.*, the commitment of a child to a state institution through a process which involves the state throughout. The Fourteenth Amendment's protections clearly would not extend to the totally private, non-statutory placement, by parents, of a child into a private hospital. It is a far different matter when parents utilizing a state statute, seek commitment of a child to a state institution for placement or treatment at state expense. *Cf. Cooper v. Aaron*, 358 U.S. 1, 4 (1958). Then, too, unlike *Jackson*, the state is directly involved here with making a decision to institutionalize as to each individual child. In *Jackson*, the decision to terminate utility service belonged solely to the private company that owned the utility.

B. The State Action Present Under The Challenged Statute Is Not Diminished By The "Discharge Upon Application" Procedure.

The State seeks to dilute the nature of its involvement in the detention of the child by referencing the portions of the challenged statute which provide for discharge upon application of the parents.[9] Their

[9] Ga. Code Ann. §88-503.3.

apparent argument is that there is not "state action" in the continued detention of the child because the child may be discharged with his parent's consent at virtually any time. The argument is without merit. Under the statutory scheme under attack, the hospital superintendent is the detainer of the child. The child has a right to leave the hospital only when both the hospital and his parents agree.[10] The illusory possibility that a child may be discharged upon application of the same parents who committed him and upon agreement of the state does not make his or her detention in the state hospital any less a deprivation of liberty by the state nor diminish the state's involvement in the detention.[11]

II.

A JUVENILE HAS A LIBERTY INTEREST WHICH IS PROTECTED BY THE FOURTEENTH AMENDMENT WHEN HE IS ADMITTED AND DETAINED IN A STATE MENTAL INSTITUTION.

This case presents the limited issue of whether a juvenile may be indefinitely and involuntarily confined

[10] Dr. Filley, A. 786.

[11] Even if the hospital seeks to release children on its own, such release is conditioned upon finding parents who are ready, willing and able to accept their child. As the trial court noted, the absence of parents ready, willing and able to accept their child is unfortunately a normal situation. Opinion of the District Court, 412 F.Supp. at 135. It is difficult to perceive how these same parents, who refuse to accept their child when the hospital seeks release will seek to release on their own. As one witness suggested, some still look upon mental hospitals as a "dumping ground." *Id.* at 138.

in a state mental institution pursuant to Ga. Code §88-503.1 without the benefit of Fourteenth Amendment due process protections. Appellees contend that the use of this statute results in a drastic curtailment of the minor's liberty interest without any due process safeguards.

As a result of this course of action, a minor's liberty is drastically curtailed without any due process safeguards.

The nature of the "interest at stake"[12] is the juvenile's right to be free from unwarranted physical confinement as one of the most basic aspects of constitutional liberty. *Arnett v. Kennedy*, 416 U.S. 134, 157 (1974). Commitment to a mental institution involves a massive curtailment of liberty, *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), which necessitates the imposition of procedural due process safeguards. *See O'Connor v. Donaldson*, 422 U.S. 563, 580 (1972) (Burger, C. J., concurring). The state, acting alone, is constitutionally prohibited from restricting an adult's liberty by commitment unless such action is accompanied by procedural due process. Similarly, this Court has held that a state may not deprive a minor of his liberty in a juvenile delinquency proceeding without due process safeguards; notwithstanding the state's role as *parens patriae* and its claims that such action was in the child's best interest. *In re Gault*, 387 U.S. 1 (1967).

Ten years have passed since this Court announced that "neither the Fourteenth Amendment nor the Bill of Rights is for adults alone," and rejected the notion that "the basic rights of a juvenile is not to liberty but to custody," *In re Gault*, 387 U.S. 1, 13, 17 (1967).

[12] *Board of Regents v. Roth*, 408 U.S. 564, 570-71 (1972).

The Court has held in that time that the liberty interest of juveniles is implicated in questions involving juvenile delinquency proceedings (*In re Gault, supra; In re Winship*, 397 U.S. 358 (1969); *McKeiver v. Pennsylvania*, 403 U.S. 528 (1970); *Breed v. Jones*, 422 U.S. 519 (1975)); suspension from school (*Goss v. Lopez*, 419 U.S. 565 (1975)); abortion (*Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976)); and corporal punishment by school authorities (*Ingraham v. Wright*, ____ U.S. ____, 97 S.Ct. 1401, 1414 (1977)).

Thus, it seems evident that where a juvenile is incarcerated by the state in a state mental institution that a *de minimis* level is far surpassed and Fourteenth Amendment liberty interests are implicated.

III.

THE SEVERE DEPRIVATIONS FACED BY AN INSTITUTIONALIZED JUVENILE WHEN VIEWED IN LIGHT OF PARENT/CHILD CONFLICT, AND THE UNRELIABILITY OF PSYCHIATRIC DIAGNOSIS REQUIRE THE MINIMAL DUE PROCESS SAFEGUARDS ENUNCIATED BY THE DISTRICT COURT.

This Court has identified three factors which must be considered against the background of "history, reason, [and] the past course of decisions" in determining what constitutes due process in a particular situation:

> Identification of the specific dictates of due process generally requires consideration of three distinct factors: first, the private interest that will be effected by the official action; second, the risk

> of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

Mathews v. Eldridge, 424 U.S. 319, 335 (1976); *see also Ingraham v. Wright*, ____ U.S. ____, 97 S.Ct. 1401, 1414-15 (1977).

Appellee would pause to emphasize at the outset of this discussion that while the underlying interest set forth in the *Mathews v. Eldridge* test are quite germane and the test is helpful to a point, the district court never had to reach the issue of the full range of the "specific dictates of due process." The district court, after finding the Georgia statute (Ga. Code §88-503.1) constitutionally defective, found that other Georgia statutes for the commitment of juveniles to mental institutions were not attacked, and were still available. Thus, to the extent that portions of the *Mathews v. Eldridge* test suggest a situation where the Court must set forth an analysis of additional safeguards that will be required, the test is not fully applicable. Appellee will examine in detail the interests involved, the risks involved under present procedures, and then present some consideration of the probable value and burdens of the limited due process protections mentioned by the Court, and the impact of using other existing mental commitment laws. Appellee will not attempt to deal with the probable value of and burdens of possible additional formats which may in the future be adopted by the Georgia General Assembly.

A. Confinement In A State Mental Hospital Involves Not Only Physical Restraint But Also Subjection To The Long-Term Adverse Effects Of Institutionalization; Accordingly, The Juvenile's Liberty Interest Is Paramount.

The district court, paraphrasing a portion of this Court's decision in *In re Gault, supra,* aptly described what a child encounters when he is committed to a state mental institution:

> Ultimately, however, we confront the reality of that portion of the mental health process with which we deal in this case. A child is alleged to be emotionally disturbed. The child is admitted to a mental hospital where he may be detained and restrained of liberty for years. It is of no constitutional consequence—and of limited practical meaning—that the institution to which he is admitted and in which he is detained is called a hospital. The fact of the matter is that however euphemistic the title, a regional hospital named Central State Hospital or Georgia Mental Health Institution is an institution known by all as one for the confinement of mentally ill children and adults, in which the child is confined for a greater or lesser time. His world becomes a building with locked doors and windows, regimented routine and institutional hours. Instead of mother and father and sisters and brothers and friends and classmates, his world is peopled by psychiatrists, psychologists, social workers, state employees and children who are to a greater or lesser extent, also emotionally disturbed.[13]

In considering the interests of the juvenile, it is beyond question that substantial adverse effects may

[13] Opinion of the District Court, 412 F.Supp. at 137.

result from any commitment to a mental institution.[14] The effects may be physical or mental, may vary in intensity, but their severity is beyond question. The confining nature of the institution, the consequent loss of family, and its replacement by the institution, the indefinite nature of the confinement, and finally the lasting stigma which accompanies the juvenile even after release–these are the realities confronting this Court.

1. Institutional life is regulated, regimented, and repressive.[15]

As in *Gault,* it is claimed that the mental institution does not severely restrict the minor's liberty; that it serves a rehabilitative purpose. In fact, the alleged

[14] While these effects fall upon all juveniles committed to Georgia's mental hospitals, they are especially harsh on children who have no need of incarceration. Neither the state nor the parents have an interest in committing children to institutions who are not in need of institutionalization. Thus, the consequences of incorrect or ill-advised commitment are indeed enormous and because of these enormous risks, every reasonable step to provide reliability should be exercised.

[15] There are distinctions between institutionalization and other forms of medical treatment which are both apparent and sound. Unlike surgery, for example, institutionalization involves a possibly permanent removal of the child from the family home and also a particularly virulent form of stigmatization. And in the case of institutionalization, confinement and deprivation of basic liberties is not merely a *by-product* of the medical procedure (as in the case of an overnight stay or longer for surgery), but rather is the *essence* of the "treatment." Chambers, "Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives," 70 Mich. L. Rev. 1108,

(continued)

mentally ill minor is removed from society and placed in a "total institution" in which every aspect of his life is regulated by impersonal authority. E. Goffman, *Asylums,* (1961). Life in a state mental institution is in many ways as routine and regimented as a prison. J. Kate, J. Goldstein and A. Dershowitz, *Psychoanalysis, Psychiatry and the Law* 700-02 (1967).[16]

The difference between a mental institution and a training school can be and appears to be a matter of labels. In 1973, a commission was formed to study mental health services for children and youth in Georgia [hereinafter Georgia Study Commission]. More than half of the minors confined in regional hospitals could be "identified as youthful offenders, except they have not been sentenced." Ga. Study Commission, A. 915.[17] It is not uncommon to find that young people who might be classified as delinquents, subject to due process safeguards, are instead confined in mental institutions.[18]

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1160-61 (1972). No other medical treatment, with the possible exception of sterilization, abortion, and psychosurgery involves so massive a curtailment of liberty and so direct a potential conflict of interest. And even with those forms of treatment, there may be insufficient state action to trigger the protection of the Due Process Clause.

[16] *See Barry v. Hall*, 98 F.2d 22 (D.C. Cir. 1938) (comparison of prison inmate and mental patient).

[17] *See also Bartley v. Kremens*, 402 F.Supp. 1039, 1044 (1975); Dr. Gates, A. 301.

[18] *See* Weiss & Pizes, "'Hospitalizing the Young: Is It For Their Own Good?" 54 *Mental Hygiene* 498 (1970).

The physical restrictions upon life in an institution are also similar to a penal facility. One of the institutions involved in this suit where both named plaintiffs were incarcerated for over five years each, Central State Hospital at Milledgeville, embodies all of these aspects of institutionalization. Milledgeville began its operations in 1842, and was at one time, with over 12,000 inmates, the largest mental institution in the world. Brown, "The Milledgeville Story," 14 Mental Hospitals 582 (1963); A Deutsch, *The Shame of the States* 88-95, 113-14 (1948). The institution has been the subject of recurring scandals of patient neglect and abuse. Brown, *supra;* Deutsch, *supra.* By the time of the hearing in this case, the institution still held 7,523 inmates. 412 F. Supp. at 120.

Each member of the three judge panel inspected this institution, as well as Georgia Regional Hospital, a newer facility in Atlanta.[19] They carefully and thoroughly investigated the nature of the confinement experienced by minors confined in Georgia's mental health facilities.[20]

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[19] Georgia Regional Hospital–Atlanta was operational in 1965, 412 F.Supp. at 119, n.11, and has special programs for children, *see* A. 914-15.

[20] Appellant's characterization that the district court "assumed" there were severe restraints on a minor's liberty ignores the court's personal inspection. Brief of Appellant, p. 48. "On two separate occasions, the three judges of this court have visited two of Georgia's eight regional mental hospitals . . . and witnessed for themselves the facilities in which plaintiffs are confined. During these visits, the court talked at length with the defendants, hospital personnel, and some of the plaintiffs." Opinion of the District Court, 412 F.Supp. at 119.

The rehabilitative nature of such institutions is subject to question. The Study Commission found that the physical facilities at Central State were "decrepit" and at another institution "so poor that very little treatment can be done (only behavior control for adjusting to institutional expectations)." A. 914-15. Unfortunately, many state institutions are understaffed, underfinanced, and overcrowded.[21] Despite an alleged effort to differentiate between minors and adults, in some institutions minors twelve or older are confined on wards with adult patients suffering from a variety of mental illnesses. Ga. Study Commission at C-1; Dr. Bowling, A. 360.[22] Georgia is not alone in this practice.[23]

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[21] See Hobbs, *Futures of Children, supra*, at 127-28: "Overcrowding is commonplace. Many residential facilities have as many as 25 to 50 percent more residents than they were intended to serve. Buildings that are old and poorly designed also create problems. For instance, lavatory and toilet facilities are often poorly maintained and may even be nonfunctioning. Ancient facilities may make it difficult if not impossible to prepare food in a sanitary fashion; and climate control may be so inadequate as to leave buildings either too hot or too cold. Equally inadequate are modern complexes of steel, chrome, and glass, when human caring is absent."

[22] Minors age twelve and over are not subject to any special screening process and are treated as adults. A. 372-73. The reason for this differentiation is supposedly a policy of the appellants. A. 377.

[23] Over fifty percent of all juveniles admitted to state, county and private mental institutions in 1971 were placed on adult wards. *See* Nat. Instit. of Mental Health, *Hospital Inpatient Treatment for Emotionally Disturbed Children, United States, 1971-1972* 1 (1972).

This is not to suggest that Georgia has failed in recent years to make progress in upgrading its facilities and services. However, even the gradual improvement of the system will not end the adverse effects described throughout this section. As one expert witness noted:

> Generally speaking, institutions run in a regimented fashion; they deal with numbers of people, so that procedures, regulations, policies, routines, schedules have to accommodate the needs of the staff in managing large numbers of patients rather than the more specific individual needs of the . . . of any individual person. I believe that *no matter how forward looking and progressive the institution,* there is inevitably some tendency to sacrifice the needs of the individual patient for the needs of institutional efficiency. (Emphasis added).[24]

In addition to poor physical facilities and locked buildings, the regimented routine, noted by the lower court, often substitutes for the rehabilitation alleged to be present in these institutions, and in fact children may become sicker.[25] These factors have led the Joint Commission on Mental Health of Children to conclude:

[24] Dr. Messinger, A. 176-77. Dr. Messinger further elaborated on the immediate and long-term adverse effects of drugs on mental patients; more specifically, the effects on J.L. A. 185. Dr. Filley concurred as to adverse effects produced. A. 762.

[25] "Go to a big state mental hospital in almost any state and ask to visit the children's ward. If you are allowed to visit, you will find people, children and staff alike, caught up in a no-exit game. Patients and staff play their roles, each defined by the other, both prescribed by elaborate regulations and procedures that serve one purpose: to maintain the stability of the institution. Most of these institutions are so large, so unwieldy,

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> Thousands of our children and youth continue to be herded into large, depersonalized institutions where custodial care, rather than remediation, is still the order of the day.
>
> *Social Change and the Mental Health of Children (Summary and Recommendations)* at 8.[26]

This regimented routine also effects the child's development. Adjustment to a regimented or structured routine can result in a loss of skills to cope with life outside the institution. N. Hobbs, *Futures of Children: Categories, Labels, and Their Consequences,* 135-36 (1974) (notes omitted).[27] Instead the juvenile adapts to institutional life and models his behavior on the inappropriate behavior of other patients. Dr. Wayne

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so antiquated in design, so poorly staffed, so burdened with the miseries of man that everyone involved must devote most of his energies to maintaining a steady-state situation. The metaphor of illness rules. Change in or deviation from role requirements cannot be tolerated. Apathy goes unnoticed. Precise adherence to role expectation is praised and rewarded, while deviations and serious efforts to change the system are punished. In such a setting, hospitals can indeed make children sick." Hobbs, *Futures of Children, supra*, at 130.

[26] *See also* Dr. Dorothy Miller, "Rehabilitation of Mentally Ill Children: A Position Paper;" Joint Commission on Mental Health of Children, *The Mental Health of Children: Services, Research, and Manpower*, p. 48: "public institutions have become 'psychiatric graveyards' or warehouses for many of these children."

[27] This "institutional dependence" combined with the lack of "continuity of relationship" can in itself lead to deliberately intended bizarre behavior. *See* Patient No. 8, A. 896, ". . . this is an institutionalized child who knows all the ways to express craziness and get need taken care of. . . ."

Hodges, A. 22; Ga. Study Commission, A. 904. Both named plaintiffs, J.R. and J.L., suffered from institutionalization as noted by one of the expert witnesses:

> I was especially concerned about the rather lifeless, passive self-effacing tendencies of [J.R.] who did not seem to be able to speak his mind or present his point of view and wishes in a forward and vigorous way. J.L. is obviously clamoring for a home life and asks very explicitly to be taken care of in a family setting, as did [J.R.].

Dr. Messinger A. 184.

Even adolescents who undergo short-term hospitalization can be effected by "institutional dependence." Hobbs, *Futures of Children, supra,* at 135. Since a child's concept of time is different than that of an adult, the effects of being in an institution are incurred much earlier and are more pronounced.[28]

Thus, despite claims that a minor is institutionalized for rehabilitative purposes, the above factors demonstrate that "the fact remains that it is incarceration.

[28] Dr. Messinger, A. 178-79. "The longer the stay in the hospital, the greater the likelihood of what's commonly called institutionalization; that is, acceptance of the kind of routine and regimented life of an institution. However, if a child is in a hospital even for what in our eyes is a brief period of time, those effects can nevertheless be quite damaging for two reasons. One is the child's perception of time is quite different from an adult's perception of time, and a day or a week or a month in the life of a child from a developmental point of view as well as from their subjective point of view is quite different from that duration of time for any of us as adults. Secondly, the stigma, both public and subjective of being in a psychiatric hospital, will be present whether one is in for a day or for a year or five years."

The rehabilitative goals of the system are admirable, but they do not change the drastic nature of the action taken. Incarceration of adults is also intended to produce rehabilitation." *Breed v. Jones,* 421 U.S. 519, 530, n.12 (1975). The adverse consequences of such incarceration on a juvenile are clear—and severe.

2. The juvenile is deprived of the continuity of relationships with family and friends.

The institution becomes the juvenile's entire world; as a result, he loses contact with both his family and community. As psychological authorities have noted, a child's normal development is dependent on the "continuity of relationships" that involvement with a non-institutional environment provides.[29] Even in institutions where care, safety and stimulation may be provided" the institution is ordinarily unable to provide a child with the "environmental influences . . . essential for a child's normal development." J. Goldstein, A. Freud, & A. Solnit, *Beyond the Best Interest of the Child* 21 (1973).

The treatment programs in Georgia state mental hospitals were described as "institutional in character and extremely limited in opportunities for normal childhood experiences." Ga. Study Commission, A.

[29] Dr. Messinger, A. 176; Dr. Mazur, A. 484 ("To remove a child from its home environment is a much more serious step than to remove an adult.")

915.[30] The lack of such normal development was described by Dr. Messinger after visiting with J.L., one of the named plaintiffs:

> One of the things that I noticed about Joey is that he was–he latched onto whoever seemed to offer him what I would call a feeding experience, a nurturing experience, giving experience, at that moment. . . . [I]n an institutional setting because one doesn't have the mother and father to whom one can rely on for nurturance over an extended, really indefinite period of time, one has to make use of whoever is available at the moment. Also, one learns that the good guy or the good woman who might be available today might not be available on the next shift or . . . the next week or month, so one takes what one can when one can. I saw a great deal of that mentality in Joey.

A. 212.

The problem is made more severe, and in fact was so in J.L.'s case, because parents can be reluctant to participate in the treatment of the child or to take their child back.[31] As the district court found, based on the testimony of the state's own professionals, there are parents who "actually abandon their child to the state," 412 F. Supp. at 138.[32] and who utilize state mental

[30] A "big brother or big sister" who is to provide "personalized individual attention" to a minor patient spends 30 minutes a week with a child. A. 342.

[31] *See* Affidavit of Janet Scott, A. 59-61. J.L.'s adoptive mother and stepfather went so far as to attempt to relinquish their rights to J.L. to Central State Hospital (albeit unsuccessfully). A. 104-06.

[32] "The big problem is very often not getting the child well enough to go home, but getting the parents essentially, you know, [to] even take this child. Dr. Kuglar, A. 579.

institutions as "dumping grounds" for unwanted children.[33] Thus, the minor is caught in a vicious cycle, losing contact with both parents and community, producing increased anxiety and the likelihood of longer institutionalization.[34]

The child's interest in remaining as an active member of his family and participant in his community is significant. Just as a parent has an interest in not being "needlessly . . . separate[d] from his family," *Stanley v. Illinois*, 405 U.S. 645, 653 (1972), so does the minor in not being separated by needless confinement in an institution. Opinion of the District Court, 412 F. Supp. at 136.

3. Confinement is indefinite.

The next element to be noted about the effects on the deprivation of juveniles' liberty under the Georgia statutory scheme is its duration. Under the challenged statute, the confinement of the child can last until the child reaches maturity, and there is no provision for meaningful periodic review. The named plaintiffs were each confined for more than five years despite the hospital's recommendations for placement outside the institution as early as 1973.[35] The average length of

[33] Dr. Filley, A. 768.

[34] *See* Reiger, "Changing Concepts in Treating Children in State Mental Hospitals," J. Child Psychotherapy 89, 104 (1972). *See* Ga. Study Comm'n., A. 917.

[35] Although there was a review of J.L.'s case in 1975 [A. 351], it noted only his presence. Despite a statutory requirement that patients be released when no longer in need of

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confinement for the class as a whole was 248.6 days, and at Milledgeville it was 456 days.[36]

4. The stigma of institutionalization effects the minor both during his confinement and after his release.

A minor who is institutionalized can also suffer from "the development of a negative self-concept and vulnerability to rejection by one's peers, as well as the

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hospitalization [Ga. Code §88-503.2], superintendents agreed that release only occurs when there is a willing parent or guardian. If the parent is not available or the state is unable to locate an alternative placement, the juvenile continues to be hospitalized, and thus, a cycle begins. As the child grows older, he is harder to place [412 F.Supp. at 135], and the longer he stays, the more he becomes institutionalized, and the likelihood of placement outside the institution diminishes.

[36] Opinion of the District Court, 412 F.Supp. at 120; *Compare Goss v. Lopez, supra*, 419 U.S. at 576 (ten day school suspension).

The National Institute of Mental Health has reported: "that thousands upon thousands of elderly patients now confined on the back wards of . . . state (mental) institutions were first admitted as children thirty, forty, and even fifty years ago. A recent report from one state estimates that one in every four children admitted to its mental hospitals "can anticipate being permanently hospitalized for the next 50 years of their lives." Joint Comm'n on Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970's* (1969) pp. 5-6.

limitations on access to various opportunities."[37] This concept, commonly called "stigma," effects the mental patient both during and after release. It connotes both a sense of shame by the patient and a discriminatory reaction by others and each acts as a cause or effect of the other.[38]

The existence of stigma whether self, social, or both, on ex-mental patients is recognized by a majority of the mental health profession.[39] Courts considering this issue

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[37] Hobbs, *Futures of Children, supra*, at 135-36 (notes omitted). Hobbs continues by noting that: "This potential stigma is particularly difficult for an adolescent, whose major task is to develop a coherent sense of identity and a foundation of self-esteem. To find himself the object of fear or distrust or to discover that his chances for employment, admission to college, securing a driver's license, or entering military service are diminished can only be disheartening."

[38] *See* Cumming & Cumming, "On the Stigma of Mental Illness" 1 *The Community Mental Health Journal* 135-36 (1965).

[39] *See, e.g.*, Cumming & Cumming, *supra* at 136-37; Farina, Ring, "The Influence of Perceived Mental Illness on Interpersonal Relationships," 70 J. of Abnormal Psychology 47, 50 (1965) ("believing an individual to be ill strongly influences the perception of that individual; this is true in spite of the fact that his behavior in no way justifies these perceptions."); Miller & Dawson, "Effects of Stigma on Re-employment of Ex-mental Patients," 49 Mental Hygiene 281 (1965); Hobbs, *Futures of Children, supra*, at 26, 34, 143; Dr. Messinger, A. 178; Dr. Mazur, A. 512; It also recognized that the effects of stigma are much greater on members of the lower class, and that this class constitutes a proportionately higher rate of the institutional population. Schwartz, Meyers, and Astrachan, "Psychiatric Labeling and the Rehabilitation of the Mental Patient," 31 Arch. Gen. Psychiatry 329, 333 (1974). Even the superintendents of Georgia's regional hospitals recognize stigma as unfortunate, but nonetheless a reality. Dr. Mazur, A. 512.

have also acknowledged its existence and its harmful effect.[40] The necessity to protect this aspect of liberty has also been stressed in cases involving juveniles. *See In re Gault, supra,* 387 U.S. at 23-24; *Breed v. Jones, supra,* 421 U.S. at 530; *Goss v. Lopez,* 419 U.S. 565 (1975).[41] The need for full procedural protections is particularly strong where the stigma of institutionalization is clearly recognized and which some commentators have noted may be more lasting than imprisonment for commission of a crime.

B. Although Parents Have A Right To The Care, Custody, And Control Of Their Children, When They Involve The State In Making A Decision To Institutionalize Their Child In The Context Of The Potential And Actual Conflicts And Pressures Inherent Therein, That Right Is Subordinate To The Juvenile's Liberty Interest.

The minor facing institutionalization is not the only person whose interest is affected, for the parent is also

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[40] *See, e.g., Donaldson v. O'Connor,* 493 F.2d 507, 520 (5th Cir. 1974) *vacated and remanded sub. nom.* 422 U.S. 563 (1975); *In re Ballay,* 482 F.2d 648, 668 (1973); *New York Association for Retarded Children v. Rockefeller,* 357 F.Supp. 752, 762 (N.D. N.Y. 1973).

[41] The constitutional status of stigma as a liberty interest in this case is not negated by this Court's holding in *Paul v. Davis,* 424 U.S. 693 (1976) because that case specifically recognizes the Fourteenth Amendment implications of stigma where the state, by the same stigmatizing action, deprives the individual of other statutory or, as here, constitutional rights.

affected by the change in the child's status. The parent's right "to direct the upbringing and education of children under their control" has long been recognized. *Pierce v. Society of Sisters,* 268 U.S. 510, 532 (1925). However, the state "may restrict the parent's control," [*Prince v. Massachusetts,* 321 U.S. 158, 166 (1944)] if it appears that the parental decision will jeopardize the health or safety of the child, or have a potential for significant social burdens." *Wisconsin v. Yoder,* 406 U.S. 705, 234 (1971). In defining the safeguards required by the Fourteenth Amendment, the weight of the parent's interest must also be examined.

This Court has consistently acknowledged the importance of the doctrines of family privacy, *Moore v. City of East Cleveland,* ____ U.S. ____, 97 S.Ct. 1932 (1977), and parental autonomy, *Meyer v. Nebraska,* 262 U.S. 390 (1923). These interests, assuming they are significantly present at the time a parent seeks institutionalization, are not adversely affected by the requirement of due process safeguards. In some cases, these safeguards will help to maintain this autonomy by increasing the likelihood of appropriate placement or determine that these considerations are no longer relevant because of the dysfunctional nature of the family.

The interest of the parent, whether a dysfunctional or an intact family, is not to be free of the child (except perhaps in respite period circumstances). For one reason, going back home is not the only alternative to institutionalization. Moreover, the parents' interest is not family privacy or family relationship free from intrusion by the state in this context, because it is the

family that has asked the state to remove the child from the home. Specifically, the parents' most legitimate and dominant interest is to obtain the best available and most appropriate mental health care for the child. The same interest is shared by the state in its *parens patriae* role.

Obviously, these interests do not exist where the state as guardian [acting through 159 county Department of Family and Children Services offices (hereinafter DFCS)] acts to institutionalize a minor, such as J.R. In such cases the state may act to institutionalize simply because a social worker determines that foster care is unavailable or unworkable. Gladelle Whitaker, A. 426-434 (a decision to institutionalize by DFCS is not subject to review within the agency or guided by any state policy). This arbitrary deprivation of liberty by the state can only be protected by due process hearings. As Justice Stevens has noted, the status of legal guardians does not give public officials "carte blanche to disregard a child's constitutional rights." *Vann v. Scott*, 467 F.2d 1235, 1240 (7th Cir. 1972).

It is important to examine the context in which the parent decides to apply to the state for institutionalization of a minor. "[I]t's by now a truism built over maybe fifty years of clinical experience . . . that the pathology of children is inextricably related to the pathology of the family. . . ."[42] As a result of their personal, inextricable involvement with the child's (and most likely the entire family's) alleged mental problems,

[42] Opinion of the District Court, 412 F.Supp. at 133, noting testimony of both psychiatrists employed by the state and independent of the parties to the same effect.

the parents may be incapable of rationally deciding what is best for the child or the family; they may simply want to get rid of the child.

Thus, although the child may not suffer from mental illness to the extent requiring institutionalization, he may be:

> . . . a behavior problem or a learning problem or a difficult child for which agencies will not take responsibility, so as the most expeditious bureaucratic maneuver the child is hospitalized; and I think that the case with the two patients that are in question in this case.

Dr. Messinger, A. 170. At another level, family harmony may be disrupted by failures in communication, by honest differences in values, or by the "generation gap," Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions." 62 Cal. L. Rev. 840, 851 (1974).[43] Finally, parents may also unconsciously project onto the child wishes or undesirable characteristics they wish to defend against. Dr. Messinger found an example of such

[43] "Parents may be confused, bewildered, and saddened by what they perceive as their child's crazy behavior. In individual cases there may be some validity to the parents' belief in a connection between acceptance of counter-cultural styles and emotional difficulties, but parents' own visceral reaction to the different lifestyle may color their own diagnosis. Where parental action does result in unjustified commitment, it is probably not due to malevolence or filial hatred but to a feeling more akin to irritation or to embarrassment over the child's unconventional behavior. The level of irritation or embarrassment can become acute and reach a level where parents become desperate." *See also*, B. Ennis and L. Siegel, *The Rights of Mental Patients* 38 (1973); Dr. Messinger, A. 166.

"scapegoating" in the case of J.L., whose mother was concerned about the effect of J.L.'s behavior on her new husband and child. A. 96. As Dr. Messinger described the effect:

> And I think he (J.L.) was, in a sense sacrificed for that marriage to be preserved. It's [scapegoating] rarely seen in that kind of clarity, but it happens in more subtle fashion frequently. . . .

A. 193-94.[44]

With these anxieties and feelings of guilt, the concerned parents consult a state physician, lacking insight into their own problems and unable to objectively evaluate their child's situation. Even loving parents are often unable to accept a child that may be emotionally ill,[45] and thus they readily accept or even desire the opportunity to allow the state to commit the child.

State institutions often see the parent and community, not the patient, as their primary client.[46] Thus the state will institutionalize the juvenile based on the needs of the parent, not the mental health of the child.

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[44] Janet Scott, who was J.L.'s primary out-patient therapist, came to the same conclusion and did not feel institutionalization was required, A. 60; incredibly, the admitting physician did not consult with her prior to J.L.'s admission. A. 61. *See also*, patient number 832-00-2191, A. 894.

[45] Joint Comm'n on Mental Health of Children, *The Mental Health of Children: Services, Research and Manpower, supra*, 280-81; Dr. Bowling, A. 370-71.

[46] Hobbs, *The Futures of Children, supra*, 139 citing Sachoteiff, Steinfield & Tolchin, "The Struggle for Patients' Rights in a State Mental Hospital," 54 Mental Hygiene 230, 239 (1970).

J.L.'s admission to Central State Hospital presents a striking example of this. Dr. Gutierrez, of the Child and Adolescent Unit at Central State Hospital notes that J.L.'s commitment was initiated by his adoptive mother in order to save her second marriage. J.L.'s stepfather had delivered an ultimatum: that she must choose between J.L. and himself. She chose the latter.

Thus, a parent may seek institutionalization due to mental or physical strain, economic hardship, or the competing needs of family members.[47] These are not the results of ill will, but they do reflect the competing interests of the parent and the care needed for an emotionally troubled child. This conflict has been recognized by the court below and several other courts; the complex dynamics of these situations strengthens the likelihood that parents' interests can compete with those of the child. Thus, some sort of impartial hearing is necessary to resolve the varying interests and, in some cases, to assist in preserving the family. *See, e.g., Heryford v. Parker*, 396 F.2d 393, 396 (10th Cir. 1968); *Saville v. Treadway*, 404 F. Supp. 430, 432 (M.D. Tenn. 1974); *New York Association for Retarded Children v. Rockefeller, supra*, 357 F. Supp. at 762; *Horaeck v. Exon*, 357 F. Supp. 71, 74 (D. Neb. 1973); *In re Roger S.*, 19 C.3d 655 (1977); *In re Lewis*, 51 Wash.2d 193, 200-01, 316 P.2d 907, 911 (1957); *In re Sippy*, 97 A.2d 455, 459 (Mun. Ct. App., D.C. 1953).

In addition to those parents who are concerned, there are, as the court noted:

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[47] Opinion of the District Court, 412 F.Supp. at 134.

> . . . some parents whose abuse that authority and who under the guise of admitting a child to a hospital actually abandon their child to the state.

412 F. Supp. at 138. For these parents, their supposed interest in preserving the family or avoiding the effect of a hearing is inconsequential compared to the loss facing the child.[48]

For some, institutionalization provides a means to continue to deny their involvement with the child, T. Lide, S. Fleck & A. Cornellison, *Schizophrenia and the Family* 274 (1965) and to withdraw from the troubling situation. Ellis, "Volunteering Children," *supra,* 62 Cal. L. Rev. at 863. This withdrawal, as the district court found, may include actually leaving the state.[49]

In 1973, between 50 to 75 percent of the juveniles in Georgia's mental health institutions had no family, were part of severely dysfunctional families, or were in state custody.[50] Nationally, experts conclude that some degree of dysfunctional family units exist.[51] Thus, for

[48] As the Director of Georgia's Office of Child and Adolescent Mental Health Services noted: "[P]roblem here in part is the history and tradition of mental hospitals which have been dumping grounds in the past. As we try to move out of this, there are a lot of people who still treat them as dumping grounds. . . ." Dr. Filley, A. 767-68.

[49] *See, e.g.,* Dr. Miles, A. 259.

[50] This is apparently recognized by the superintendents. For example, Dr. Gates stated that a large percentage of the children coming to his institution come from broken homes. Dr. Gates, A. 284.

[51] J.C.M.H.C., *Mental Health: From Infancy Through Adolescence*, 174 [". . . many families are already broken when the child is in placement . . . (one study shows only 19 percent of families complete.)"].

many parents the valued goals of parental authority and family unity are substantially weakened at the time application is sought. More importantly, it is parents who initiate the process of having the child removed from the family (by seeking to institutionalize the child) and they who "voluntarily," in approaching the state for assistance, surrender to some extent, their right to family privacy.

This Court has recently dealt with a closely analogous situation involving both the liberty interest of the minor and of the right of parents to raise their children. In *Planned Parenthood of Central Missouri v. Danforth,* 428 U.S. 52 (1976), a state statute which gave parents an absolute veto over the right of a minor to secure an abortion was held unconstitutional. The *absolute* nature of combined power of parents and the state in this case is at least comparable to the situation in *Danforth.*

To paraphrase this Court's language in *Planned Parenthood v. Danforth, supra,* it is difficult to conclude that by providing a physician with absolute power to institutionalize a child based upon the application of the parent in the absence of any impartial hearing will serve to strengthen the family unit. Neither is it likely that such power will enhance parent authority or control where the minor and the parent are so fundamentally in conflict and the existence of an emotional disturbance has fractured the family structure.

Unlike *Danforth*, appellees do not seek to completely invalidate the parents' consent. What is sought is only an impartial forum where the problems and needs of

the child can be considered along with the concerns of the parents.[52]

C. The Risk Of Erroneous Deprivation Of The Child's Liberty Is Substantial Since The State's Admission Process Is Inadequate, Lacks Uniform Standards, And Provides No Safeguards On The Unchecked Power Of The Admitting Physician To Institutionalize. Thus, Additional Safeguards Are Required.

"There can be little responsible debate regarding the uncertainty of diagnosis in this field (psychiatry) and the tentativeness of professional judgment." *O'Connor v. Donaldson*, 442 U.S. 563, 584 (1975) (Burger, C. J., concurring) citing in part Justice Frankfurter in *Greenwood v. United States*, 350 U.S. 366, 375 (1956).

The inability to accurately diagnose mental illness is due in part, to a disagreement over what behavior can

[52] The court's opinion in Bellotti v. Baird, 428 U.S. 192 (1976), suggests that a materially different constitutional issue would be presented under a provision requiring parental consent or consultation in most cases but providing for prompt (i) judicial resolution of any disagreement between the parent and the minor, or (ii) judicial determination that the minor is mature enough to give an informed consent without parental concurrence or that abortion in any event is in the minor's best interest. Such a provision would not impose parental approval as an absolute condition upon the minor's right but would assure in most instances consultation between the parent and child.

In *Bellotti, supra*, the court vacated and remanded to allow for state court interpretation of a law which required parental consent for a minor's abortion, but permitted a judge to grant consent for good cause, if the parents refused.

be classified as "mentally ill."[53] Psychiatric judgments are effected as much by the evaluators' training, experience, class, culture, race, sex, and personal biases as by the patients' alleged condition. Ennis & Litwack, "Psychiatry and Expertise: Flipping Coins in the Courtroom," 62 Cal. L. Rev. 693, 719 (1974). In this case, experts testifying on behalf of both parties agreed with these conclusions.[54] Even the language and culture of different regions within the United States can effect diagnostic reliability.[55]

> And, because of the unavoidable ambiguous generalties in which the American Psychiatric Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there.

Livermore, Malmquist & Meehl, "On the Justifications for Civil Commitment," 117 U. Pa. L. Rev. 75, 80 (1968). As a result, minors like J.L. and J.R. are admitted with conflicting diagnoses. Dr. Messinger, A. 174. There is no one to question this conflict or its basis.

[53] Roth, Dayley, & Lerner "Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes," 3 Santa Clara L. Rev. 400, 403 (1973).

[54] Dr. Falek, A. 706; Dr. Messinger, A. 173.

[55] A problem can exist "even when a northerner . . . comes down here and does not understand southern idions." Dr. Filley, A. 765. There are foreign born or foreign trained doctors at all of Georgia's mental health facilities. *See, e.g.*, Dr. Craig, A. 533. At Central State, Spanish speaking doctors with admitted communication difficulties are assigned to the Children's and Adolescent Unit. Dr. Gates, A. 320-321.

1. Psychiatrists have a tendency to overdiagnose mental illness.

Empirical studies have demonstrated that psychiatrists and physicians employed by state mental institutions, recommend institutionalization for persons not in need of confinement.[56] This leaning toward institutionalization is the result of several factors. Psychiatrists, as part of the medical profession, tend to err on the side of caution.[57] Thus, where there is any doubt, institutionalization is preferred. Secondly, psychiatrists think in terms of psychopathology and as

[56] Dershowitz, "Psychiatry in the Legal Process: A Knife That Cuts Both Ways," 4 Trial 29, 32-33 (Feb./March, 1968); Ellis, "Volunteering Children: Parental Commitment of Minors to Mental Institutions," 62 Cal. L. Rev. 840, 363-68 (1974); Ennis & Litwach, "Psychiatry and Presumption of Expertise: Flipping Coins in the Courtroom," 62 Cal. L. Rev. 693, 711-19 (1974); "Commitment," 117 U. Pa. L. Rev. 75, 83 (1968); Rosen, "Detention of Suicidal Patients: An Example of Some Limitation in the Prediction of Infrequent Events," 18 J. of Con Psychology 397 (1954); Note, "Tne Role of Counsel in the Civil Commitment Process: A Theoretical Framework," 84 Yale L. J. 1540, 1553-54 (1975); *People v. Burnick*, 14 Cal.3d 306, 535 P.2d 352, 121 Cal. Rptr. 488 (1975); *In re Long*, 25 N.C. App. 703, 215 S.E.2d 626, 629 (1975); T. Schief, *Being Mentally Ill: A Sociological Theory*, 104-21 (1966); Bazelon, "Institutionalization, Deinstitutionalization and The Adversary Process," 75 Colum. L. Rev. 897, 900 (1975); Dr. Messinger, A. 172-173; Dr. L'Abate, A. 806.

[57] *See* Ellis, *supra*, at 865-66; Rosen, *supra*, at 385; T. Schief, *supra*, at 105-121.

a result tend to diagnose ambiguous behavior as mentally suspect.[58]

Finally, and equally as important, institutional psychiatrists often lack knowledge of community resources as an alternative to institutionalization.[59]

2. The commitment decision is based upon arbitrary policies and procedures.

The admitting physician's commitment determination is further suspect due to the inadequacy of information upon which his decision is based and the policies of the institution in which he practices. Unlike the physician and minor in *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) or the physician and adult in *Roe v. Wade*, 410 U.S. 113 (1975), the minor in this case does not select his own physician nor does he agree on a course of treatment following consultation with the physician. Rather the physician, acting on behalf of the state, evaluates and determines the necessity of confinement based upon the unverified conclusions of others and the policies of the institution (if such exist).[60] He is in effect the gatekeeper whose decision does not necessarily reflect the decisions of his "patient" and whose authority may not be questioned

[58] Shah, "Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior," 53 Mental Hygiene 21, 26 (1969).

[59] Dr. Messinger, A. 172.

[60] *See* pp. 36-42, *infra*.

by the "patient."[61] He has the awesome and arbitrary authority to confine without any checks or controls.

a. Admission procedures are arbitrary and utilize unverified information.

The admission procedure authorized by the statute fails to provide a proper basis for the decision to institutionalize in that it fails to ensure that all necessary information is obtained and to verify the validity of information relied upon by the admittting physician.

It is a truism that an admitting physician should have as much knowledge as possible concerning the child, his parents, and community. S. Chess, *An Introduction to Child Psychiatry* 47 (2nd ed. 1969). In order to obtain this information, two to three interviews over a period of time are recommended. J. Simmons, *Psychiatric Examination of Children* 6 (2nd ed. 1974); T. Schieff, *supra,* at 174.[62] Yet a diagnostic interview is often

[61] There is a distinction between a physician's diagnosis of a physical malady and its treatment, and the detection of a mental disorder. As Dr. Messinger stated: "One is not viewing . . . tissue . . . pathology that can be looked at . . . under a microscope—one is looking at complex and delicate relationships between people." A. 191. It is this difference which has caused the court to accord greater weight to a physician's recommendation of abortion than to a decision to institutionalize. *Compare Doe v. Bolton*, 410 U.S. 179, (1970) *and O'Connor v. Donaldson*, 442 U.S. 563, (1975).

[62] Several years may be required to learn the true facts. Dr. L'Abate, A. 801-02.

conducted in 30 minutes or less; and on the basis of this minimal contact the physician makes a decision which can result in the indefinite confinement of a child to a mental institution. The weakness of the present system is aptly illustrated by the admission of one of the named plaintiffs, J.L., who was admitted to Central State Hospital without any consultation with his primary out-patient therapist who felt strongly that institutionalization was not appropriate. Affidavit of Janet Scott, A. 61.

Further, the state alleges the existence of a statewide network of community mental health clinics; that the reports and referrals from these clinics are an integral part of the admission process.[63] The record indicates however, that this is an idealized conception. Dr. John Filley, Director, Office of Child Adolescent Mental Health Services stated that, "We haven't arrived at that point fully yet. We still get patients who are referred directly to the hospital . . . without recourse through the community."[64]

Testimony of the superintendents confirmed this fact.[65] Further, the community mental health centers are new programs which are just developing.[66] Few are

[63] Brief of Appellant at 33-34.

[64] Dr. Filley, A. 723. There is no statewide policy requiring referrals from community mental health clinics. *Id.*

[65] Dr. Miles, A. 250; Dr. Gates, A. 281; Dr. Bowling, A. 357; Dr. Kuglar, A. 556, 594-95; Dr. Mazur, A. 500.

[66] Dr. Filley, A. 768 "the child and adolescent services proportionately are . . . quite a bit less developed than general adult services . . . we ought to be providing 35% of services to children and adolescents. Actually, in many of the detention areas it was one-tenth or less as much service." A. 729.

able to employ full-time psychiatrists and many are overburdened.[67] These same observations apply to community mental health clinics in other states. Hobbs, N., *The Futures of Children* 216 (1975).

Although the physician often relies upon reports from others (notably the child's parents), there is no policy or procedure to verify this information. If there is a statement from a social worker or a clinic recommending admission, it is accepted as valid without further inquiry.[68] Where there are conflicting reports, it is still the sole decision of whoever the particular admitting physician happens to be, without any safeguards, checks, or necessity for the doctor to justify his decision.

A glaring example of such arbitrary action is demonstrated by one of the named plaintiffs. J.R. had been treated for over a year at a community mental health clinic in north Georiga. The psychiatric consultant at the clinic noted in his report of May 26, 1970 (one month prior to the child's admission) that J.R. was making progress and that "it would be of benefit to him . . . to stay in that foster home . . . since he has been in seven different foster homes and I feel that this must be very upsetting to him, and if he has to move, it would be even more upsetting." A. 153. Nevertheless, J.R.'s social worker, under pressure to find another foster home for J.R., sought institutionalization. There

[67] Dr. Mazur, A. 486, 490.

[68] "I don't know whether they get it [information] by hearsay from other persons or whether they observe it." Dr. Bowling, A. 367; Dr. Miles, A. 263; Dr. Jarrett, A. 472. "These reports are often incomplete." Dr. Gates, A. 284.

is no hospital record that the admitting physician at Central State Hospital had checked on the recommendations of the clinic concerning hospitalization; this appears even more suspect as J.R.'s degree of impairment was noted as mild on the admission forms. A. 130-34. As Dr. Filley acknowledged "DFCS [Department of Family and Children Services] takes the child to the hospital and says 'Now it's off our hands.' " A. 768.

Unfortunately, this is not a unique situation. As noted by the Joint Commission on Mental Health of Children, [and especially applicable to J.R.'s situation] "the State Hospital has been used at times by communities to relieve parents, courts, and other agencies of problem children. Referral is still too often a matter of expediency rather than a result of clinical judgment or a decision intended to provide the treatment that is most appropriate for the well-being of the individual child."[69]

If the minor's parents are available they are often relied upon to provide the primary information upon which the physician bases his diagnosis. Yet as the district court found, "the pathology of children is inextricably related to the pathology of family. . . . [M]ore often than not the parents as well as the child might need psychiatric help."[70] Rarely, if ever, will you have a purely emotionally disturbed child in a family

[69] Joint Comm'n on Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970's*, p. 283.

[70] Opinion of the District Court, 412 F.Supp. at 133, citing Dr. Messinger, A. 163.

with no other problems . . . where there is a mentally ill child . . . it relates to the parents.[71]

Due to their own involvement or anxiety, the parents are more likely to focus on the behavioral characteristics of the child that they find unpalatable or which they consider sick and deviant.[72]

It follows that since parents are not neutral bystanders in this situation, the need for complete, accurate and verified information about the child prior to institutionalization is that much more compelling.

b. Commitment occurs in the absence of uniform admission policies and may be based on the subjective personal and professional views of the admitting physician.

There are no statewide policies which define the factors that are to be considered by a psychiatrist in making a determination as to the need for commitment. Dr. Skelton, A. 219-220. As a result, there is no uniformity as to admission policies within the state; each institution is free to develop its own policies or to

[71] Opinion of the District Court, 412 F.Supp. at 133, citing Dr. Jarrett, A. 473 and Dr. Bowling, A. 371.

[72] Dr. Messinger, A. 166. Parents may distort or forget valuable facts. S. Chess, *supra*, at 73. Although experts recommend that both parents be consulted and interviewed prior to admission, psychiatrists often see only one parent before making the decision to institutionalize. J. Simmons, *supra*, at 116-17, 122; S. Chess, *supra*, at 50-54.

leave the admission decision solely to the discretion of the individual physician.[73]

Consequently, the decision as to whether a juvenile will be committed depends not only on the particular personal and professional views of the admitting physician who happens to be on duty, but also on the particular regional hospital where initial evaluation and diagnosis is conducted. For example, a juvenile would be accepted at Georgia Regional Hospital at Atlanta only if his behavior was found to be out of control and "constituting a danger to themselves or others"[74] while the same child could be admitted to the Regional Hospital at Savannah if "he had been tried in other situations and not made it."[75] Clearly then, there can be no uniformity within the psychiatric profession as to when institutionalization is required and as to how this determination is reached.

Finally, complex psychiatric determinations aside, juveniles are sometimes admitted and confined simply because no one knows what else to do with them.[76] Thus, the record reflects that one child was admitted and confined at West Central Regional Hospital due to a "lack of community resources" while another juvenile remained confined because the community mental

[73] The admission decision may depend on a physician's subjective judgment of a family's home or socio-economic condition. R. Glascote, *et al., Children and Mental Health Centers* 973 (1972).

[74] Dr. Bowling, A. 356. Compare with Dr. Filley's opinion that dangerousness "is a fairly rare thing for children." A. 727.

[75] Dr. Craig, A. 524. *See* Central State Hospital Criteria for Admission, A. 346-49.

[76] Dr. Messinger, A. 170.

health center was unable to pick him up due to "work pressures."[77]

The foregoing evaluation of the state's admission process need not be construed as an "indictment of the psychiatric profession."[78] Even if written procedures, guidelines, and policies existed and applied uniformly throughout the state, and even if referrals from community mental health clinics were mandatory prior to admission, the present admission system would not be sufficient. The lack of even this minimal degree of uniformity and reliability points to an even greater likelihood of error in inappropriately institutionalizing a child under the present system.

Fundamental notions of due process demand that there be something more—a check on the absolute and arbitrary power of parents and the state to institutionalize a child when what is at stake is the freedom of the child, or conversely, the confinement of that child in a state mental institution possibly until his 18th birthday. The child's liberty interest demands nothing less.

D. This Court Need Not Determine The Full Range Of Due Process Safeguards Necessary To Protect A Juvenile Facing Confinement In A Mental Institution.

Not unsurprisingly, the lower court unanimously found that "neither the statutory scheme nor the

[77]A. 896, 895.

[78]Brief of Appellant at 20.

practices and policies of defendants provide for any procedural safeguards."[79] The three-judge panel did not attempt to determine the entire question of "what process is due" the juvenile.[80] *Morrissey v. Brewer,* 408 U.S. 471 (1972). It did determine that

> while the care that is implied in—the procedural regularity that is called for by the phrase "due process"—is flexible and such as the particular situation demands, *Morrissey v. Brewer,* it traditionally includes at least the right (after notice) to be heard before an impartial tribunal. *Powell v. Alabama,* 287 U.S. 45, 53 S.Ct. 55, 77 L.Ed.2d 158 (1932).[81]

Thus, the district court [and affirmance of its decision by this Court] requires only that the state provide notice and a hearing conducted by an impartial tribunal before it acts to indefinitely deprive a juvenile of his liberty by confining him in an institution. Further, the Court did not even deal with the parameters of the concept of "impartial tribunal"; thus, this court need not reach the issue of what specific due process

[79]Opinion of the District Court, 412 F.Supp. at 137.

[80]*See also, J.L. v. Parham*, 412 F.Supp. 141, 143 (M.D. Ga. 1976) (stay den.) "Unlike *Kremens [v. Bartley, supra]* the decision of this Court is only that some due process is required." A. 940-41.

[81]Opinion of the District Court, 412 F.Supp. at 137. As Daniel Webster's well-chosen words suggest, it "mean[s] a law which hears before it condemns, which proceeds on inquiry and renders judgment only after trial." Black's Law Dictionary, Revised 4th Ed. at 590; partially quoted in *Powell v. Alabama, supra.*

safeguards are required or the parameters of those safeguards.[82]

Contrary to appellants' assertions[83] the court in its order did not prohibit the state from providing mental health services to mentally ill children. It merely foreclosed the use of one specific method of commitment which did not pass constitutional muster. Noting that the full protections enunciated in this Court's decision in *In re Gault, supra,* were contained in the Georgia Juvenile Court Code,[84] the lower court allowed use of this statute, but did not prescribe the use of the juvenile court system as the exclusive constitutionally sufficient means of commitment of juveniles.[85] The district court further noted the existence of other mental health laws/court systems that could be utilized to place a child in one of the state's mental institutions. Thus, the Court did not attempt to legislate, but allowed the state's policy makers to explore other

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[82]For a discussion of specific due process protections (counsel, pre- and post-commitment hearing, confrontation and cross-examination of witnesses, standard of proof, record, etc.) *see* amicus briefs. Appellees direct the Court's attention specifically to the amicus brief of the American Bar Association re: the right to counsel as a fundamental due process safeguard.

[83]Brief of Appellants, p. 52.

[84]Ga. Code Title 24A.

[85]412 F.Supp. at 136 and 139. Although the Juvenile Court Code provides that juvenile courts "shall have exclusive jurisdiction over juvenile matters and shall be the sole court of initiation action. . . ." 1971 Ga. Laws 709 (Ga. Code Ann. §24A-301) the lower court did *not* rule on the effect of this provision in this case. 412 F.Supp. at 131.

alternatives if they desired.[86] In fact, since the initial February, 1976 decision, the Juvenile Court Code has been amended to specifically provide for juvenile commitments to state mental institutions and a majority of juveniles are now committed pursuant to this statute.[87]

Since the district court did not reach the issue of specific safeguards, beyond notice and a right to be heard before an impartial tribunal, the discussion of (1) probable nature of additional safeguards and (2) the burden on the state are somewhat abbreviated. These issues will of course take on greater importance in situations where the lower court has ordered that additional protections be afforded. However, in the instant case, the district court has indicated that judicially created remedies (beyond the part of the order dealing with the 46 specific children which is treated in the last section of this brief) are not necessary. The court made it clear that the state and parents wishing to institutionalize children have several options under other state laws which were not under attack in this action, and that the Georgia General Assembly is of course, free to structure additional commitment laws as they deem necessary.

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[86]The Georgia Legislature has established a Mental Disability Laws Study Committee to study, in part, the "voluntary" commitment of juveniles and to make a report, including suggested legislation to the 1978 Session of the General Assembly. I. General Acts and Resolutions, No. 16, p. 936 (1977).

[87]Ga. Code Ann. §24A-41; 1977 Ga. Laws 774; *See* Appendix A to Appellant's Brief.

E. The District Court's Limited Holding That Due Process Includes At Least The Right After Notice To Be Heard Before An Impartial Tribunal Warrants Affirmance.

1. Notice.

This Court has consistently found that notice is a fundamental aspect of due process.[88] To be meaningful it must be provided sufficiently in advance and with sufficient detail to allow a reasonable opportunity to prepare for the hearing. *In re Gault, supra,* at 33; *Wolff v. McDonnell,* 418 U.S. 539, 563 (1974). In mental commitment proceedings, where a person's liberty may be curtailed, notice is crucial. "Developments–Civil Commitment," *supra,* 1274-75; *Cf. Goldberg v. Kelly,* 397 U.S. 254 (1970).

That this case involves minors for whom rehabilitative treatment is being sought does not diminish the necessity of notice. Speculative fears of trauma to the child are not sufficient to overcome this basic requirement of due process. This position was raised by the State in *In re Gault, supra,* at 26, and found lacking. Indeed, for the minor who is not mentally ill, the trauma of suddenly being confined in a mental institution is far greater than receiving notice.

> The humanitarian desire to eliminate or curtail the use of such notice in such cases raises certain questions however. It may be, for example, that the experience of receiving notice would prove no

[88] *Baldwin v. Hale*, 1 Wall. 223, 233 (1864); *Grannis v. Ordean*, 234 U.S. 385 (1914). *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950).

> more traumatic for the patient than suddenly finding himself in a mental institition.[89]

2. Hearing Before An Impartial Tribunal

Although the length and severity of the deprivation are factors which determine the precise form of hearing required, due process includes a basic right to a hearing of some kind. *Goss v. Lopez,* 419 U.S. 565, 576 (1975). Due to the severity and indefinite nature of the confinement inflicted on the minor, a hearing by an impartial authority is part of the minimal process that is due.

A basic requirement of due process is that a hearing be held before a "fair tribunal." *McKeiver v. Pennsylvania,* 403 U.S. 528, (1970). Fairness involves not only "an absence of actual bias" but requires that "even the probability of unfairness" be removed. *In re Murchison,* 349 U.S. 133, 136 (1954).[90] "The due process right to a competent and impartial tribunal is quite separate

[89] American Bar Foundation, *The Mentally Disabled and the Law* (S. Brakel and R. Rock, eds.) 51 (rev. ed. 1971).

[90] "Circumstances and relationships must be considered. This Court has said, however, that 'every procedure which would offer a possible temptation to the average man as judge . . . not to hold the balance nice, clear, and true between the State and the accused denies the latter due process of law' " (citation omitted) 349 U.S. at 136. *Murchison* involved a state judge empowered under state law to sit as a "one man grand jury" and to compel witnesses to testify before him in secret about possible crimes; he charged two witnesses with contempt and then tried and convicted them himself.

from the right to any particular form of proceeding." *Peters v. Kiff*, 407 U.S. 493, 501 (1972).

In two recent decisions[91] this Court found due process satisfied by allowing the initial decision-maker to review his own decision. Both cases involved school disciplinarians and in each case the weight of the protected liberty loss, although not *de minimis*, was limited by the historical development of school discipline as part of the educational process.

In *Goss v. Lopez*, 419 U.S. 565, 582 (1975), this Court required that prior to an expulsion from school of ten days or less, a student must be told what he is accused of doing and what the basis of that accusation is.[92] It was recognized that "[B]rief disciplinary procedures are almost countless. . . ." and that they are part of the "teaching process." 419 U.S. at 583.[93] Although an impartial, independent review was not necessary for short suspensions, "[L]onger suspensions or expulsions for the remainder of the school term or permanently, may require more formal procedures."[94]

The liberty interest at issue in *Goss* involved a "property" right created by the state while the

[91]*Goss v. Lopez*, 419 U.S. 565 (1975) and *Ingraham v. Wright*, ____ U.S. ____, 97 S.Ct. 1401 (1977).

[92]It was recognized that there was a need for quick action following the misconduct, but that the teacher could "informally discuss the alleged misconduct with the student minutes after it occurred." 419 U.S. 582; 419 U.S. 594 (Powell, J., dissent.) (role of teacher).

[93]Compare with a child's average length of stay in Georgia state mental institutions–248.6 days.

[94]The suspension involved at a maximum 5% of the school year. 419 U.S. at 589.

infliction of corporal punishment in *Ingraham v. Wright*[, 97 S.Ct. 1401 (1977)] concerned the freedom from physical restraint.[95] Where this basic form of liberty is subject to restraint, the full range of procedural protections are usually required to satisfy due process.[96]

An historical analysis of paddling in schools, however, indicated that due to "the low incidence of abuse, the openness of our schools, and the common law safeguards that already exist, the risk of error . . . can only be regarded as minimal. *Ingraham v. Wright, supra*, at 418.

Clearly, these factors do not exist in the mental commitment of a juvenile.[97] The admitting physician does not possess the common law privilege to commit children. The authority to commit arises by statute and implicates the liberty interest of the child. In contrast to the school disciplinarian, the admitting physician operates within a *closed* institution and bases his decision on *un*observed conduct, *un*verified reports and *un*quantifiable standards.[98] As noted, the courts have

[95]97 S.Ct. at 1414, n.43; *Goss v. Lopez, supra*, at 576.

[96]See *Ingraham v. Wright, supra*, 97 S.Ct. 1414, n.44. Monaghan, "Of 'Liberty' and 'Property,'" 52 Cornell L. Rev. 405, 411 and 414 (1977).

[97]97 S.Ct. 1411, n.37, distinguishing the doubtful application of the Eighth Amendment's prohibition on cruel and unusual punishment to school discipline but leaving open its application to confinement in mental or juvenile institutions.

[98]Compare to 97 S.Ct. 1416 ("...paddlings are usually inflicted in response to conduct directly observed.").

uniformly questioned the validity of decisions made in this manner.[99]

Further, in cases not involving the special elements of *Goss* and *Ingraham* the necessity of an impartial tribunal has consistently been recognized. *See Goldberg v. Kelly, supra.* Even where a conditional liberty, such as parole revocation, was at stake, an impartial authority has been required to determine the validity of the proposed liberty loss. *Morrissey v. Brewer,* 408 U.S. 471, 481 (1972).

The admitting physician, like the parole officer in *Morrissey v. Brewer, supra,* at 486, is "directly involved in making recommendations and cannot always have complete objectivity in evaluating them."

One commentator has differentiated between the deprivation of liberty, even conditional liberty, and other "liberty losses." He includes civil commitment to a mental institution as one of the losses that require a "high level of procedural protection."[100] In light of the substantial risk of error involved in the physician's decision to commit a juvenile[101] and the absence of any of the historical safeguards noted above, the district court's finding that the statute in question did not contain the requisite due process which must be present before a juvenile is committed to a mental institution warrants affirmance by this Court.

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[99] *See generally O'Connor v. Donaldson*, 422 U.S. 563 (1975).

[100] Friendly, "Some Kind of Hearing," 123 U. Pa. L. Rev. 1267, 1296 (1975).

[101] See Section III.C.

F. The Burden On The State (Both Administrative And Fiscal) In Light Of Its Manifest Purpose To Act In The Best Interests Of Children Through Its *Parens Patriae* Power Is Minimal.

The Court was correct in leaving to the State's discretion the use of existing procedures (Ga. Code Chapter 24A within the Juvenile Court and the other provisions of Ga. Code Chapter 88-5 in the Court of the Ordinary) or developing other permissible procedures to commit children to its state institutions. As to new procedures, it is highly speculative as to the precise burdens which will be placed upon the State since the burden will vary greatly depending upon the nature and scope of these new procedures. However, what can be assessed at this point is the impact of using existing state laws.

Since 1969, 3,140 children have been admitted to the state's mental hospitals, and 35% of this number were committed through either the Juvenile Court or the Court of the Ordinary. Opinion of the District Court, 412 F. Supp. at 120. The fact that these alternate procedures have been used in recent years gives some indication that they have not proven excessively burdensome. The state estimates that approximately 264 children will be subjected to these proceedings next year. This compares with a total of 48,116 juvenile cases handled on a yearly basis in Georgia's juvenile courts. Opinion of the District Court, 412 F. Supp. at 145. If one considers that 35% of the juvenile commitments each year have already been handled in this matter, then the estimate of additional cases in the juvenile courts will be an even smaller

amount. Thus, it is difficult to consider how the state can realistically argue that the additional safeguards provided by existing law will constitute a significant burden on the state.

IV.

CONFRONTED WITH THE STATE'S ADMISSION THAT 46 INAPPROPRIATELY CONFINED CHILDREN WERE BEING HARMED BY CONTINUED INSTITUTIONALIZATION, THE DISTRICT COURT WAS CORRECT IN HOLDING THAT THE STATE'S INSTITUTIONAL CONFINEMENT OF THESE CHILDREN COULD NOT CONTINUE.

The district court was confronted in this case with the state's own admission that 46 children were confined in state mental hospitals, pursuant to the challenged voluntary admission statute, who in the opinion of professional hospital personnel did not need to be there. Opinion of the District Court, 412 F. Supp. at 124.

The State, when queried by the Court as to their intentions regarding the prospect of placement of these 46 children outside these institutions replied that no alternative facilities existed.[102] Further after consulta-

[102] The children remained confined despite a statutory obligation upon the superintendents of the eight regional mental hospitals to release any individual whose condition has sufficiently improved such that he no longer requires hospitalization. Ga. Code Ann. §88-503.2.

tion with the Governor and state legislators, the State refused to consider reallocating money at that time for alternative facilities for these children since the children were receiving "adequate treatment" in state mental health institutions. Opinion of the District Court, 412 F. Supp. at 138-39, citing Affidavit of Dr. Skelton.

However, contrary to this assertion of "adequate treatment," the State's own professionals as well as expert witnesses noted the harm that results to children who remain in institutions when there is no need for such confinement.[103] Further, in the case of the two named plaintiffs, hospital personnel had recommended placement outside the mental institution as early as *1973* (two years prior to the institution of this action) with no action taken by the State despite notations of the harmful effects of inappropriate institutionalization on their hospital records.[104]

[103] Dr. Filley, A. 766. "[It is therapeutically harmful to fail to place a child in an alternative setting to an institution when the child no longer requires institutional care] . . . because one wants to increase the child's adaptive capabilities. One wants the child to re-establish as soon as possible ties to the family, friends, schools, other community groups, so that the longer one postpones this, the harder it makes it for the child to re-establish those ties. Childhood is a time of relatively rapid intellectual, social and emotional development. A delay is of greater importance in a rapidly developing personality than it would be in a relatively fully developed adult, who is more static in his psychological functioning. Dr. Messinger, A. 183.

[104] A. 63-66. As early as 1973, hospital personnel recommended specialized foster care for J.L. (See p. 7 of transcript of testimony of Dr. Gutierrez). That recommendation was continually reaffirmed and documented in hospital records: "Continued hospitalization would not provide the emotional climate

(continued)

Finally, the district court was confronted with the 1973 Study Commission Report on Mental Health Services for Children which noted the inappropriate hospitalization of many children and the crying need for alternative facilities to place these children in. No action was taken by the State as a result of this report.[105]

(footnote continued from proceeding page)
necessary to meet J.L.'s needs. Recommendation: J.L. be considered for foster home placement with continued out-patient therapy." [Psychological Evaluation: 6/75]. A. 109. "Foster care would be most beneficial . . . he is obviously suffering from some degree of institutionalization and should experience success in a loving, concerned relationship as soon as possible." [Summary Progress Note: 6/75]. A. 98-99.

Recommendations for foster home placement for J.R. were made in early 1973 [Summary for Placement Resource: 6/73]. A. 145. "Central State Hospital has for some months been requesting long-term foster care or (an) adoptive home . . . *it is felt that (J.R.) will now only regress if he does not get a suitable home placement as soon as possible* . . . (he) has received maximum benefits from Central State's program."

This recommendation was subsequently reaffirmed and documented in the hospital records: "efforts to obtain a foster placement should be primary at this time lest J.R. becomes a permanently institutionalized child." [Psychological Evaluation: 8/73]. A. 156. "Foster care is recommended." [Restaffing: 11/74]. A. 158.

At the time the suit was brought in October, 1975, J.R.'s psychologist indicated that J.R. was "just a mildly retarded individual who needs structure and supervision but could function much better in a setting characterized by . . . a lot less structure . . . continued hospitalization would be harmful for J.R." (Dr. Hodges, A. 29).

[105] It is the observation of both hospital personnel and the Commission that more than half of the hospitalized children and youth would not need hospitalization if other forms of care were available in the community. Study Comm'n A. 908.

Here, the State had undertaken to act in *parens patriae*[106] with regard to these children by placing them in its mental health facilities for treatment.

This *parens patriae* power of the state has been specifically recognized by the Georgia courts[107] and, as to children, the common law *parens patriae* philosophy is now codified in the Georgia Juvenile Court Code, specifically, Ga. Code Ann. §24A-101:

> This code shall be liberally construed to the end that children whose well-being is threatened shall be assisted and protected and restored, if possible, as secure, law-abiding members of society; and that each child . . . shall receive . . . the care, guidance, and control that will conduce to his welfare.

1971 Ga. Laws, pp. 709, 710.

Because the exercise of this power necessarily involves a substantial restraint on the ward's freedom, due process requires that a particular scheme for protection of the mentally ill must rest upon a legislative determination that it is compatible with the

[106] State(s) are vested with the historic *parens patriae* power, including the duty to protect "persons under legal disabilities to act for themselves." *Hawaii v. Standard Oil Co.*, 405 U.S. 251, 257 (1972). See also *Mormon Church v. United States*, 136 U.S. 1, 56-58 (1890). The classic example of this role is when the State undertakes to act as "the general guardian of all infants, idiots, and lunatics." 3 W. Blackstone, *Commentaries* *47. See generally, "Developments–Civil Commitment," *supra*, at 1207-10 (nature and origins of the power).

[107] *Yeomans v. Williams*, 117 Ga. 800, 45 S.E. 73 (1903).

best interests of the affected class, and that its members are unable to act for themselves.[108]

Given the State's admission as to the harmful effects of inappropriate institutionalization then, it is difficult, if not impossible, to draw a rational relationship between the State's purpose in confining the 46 children in question in institutions [treatment for mental illness in order to restore the child to society–Ga. Code §24A-101] and the actual nature of that confinement [unnecessary institutional confinement that was harmful to the child]; and, without some form of treatment or benefit, the state's justification for acting as *parens patriae* becomes a nullity. *In re Ballay*, 482 F.2d 648 (D.C. Cir. 1973).

Thus, the court came face to face with the doctrine of substantive due process which is best exemplified in *Shelton v. Tucker*, 364 U.S. 479, 488 (1960):

> [E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose.

In *Jackson v. Indiana*, 406 U.S. 715 (1972), this Court extended this principle to the now oft-quoted holding of that case: the nature and duration of

[108] *O'Connor v. Donaldson*, 422 U.S. 563, 583 (Burger, C. J., concurring). The purpose of exercising that power is to promote the interests of the individual. "Developments–Civil Commitment," *supra*, at 1222; American Bar Foundation, *The Mentally Disabled and the Law* at 34-40 (S. Brakel & R. Rock eds.) (rev. ed. 1971).

confinement must bear a reasonable relation to the purpose of confinement.

Clearly, as previously described, such a rational relationship did not exist in the instant case. And just as this Court further expanded *Jackson, supra*, in *McNeil v. Director, Patuxent Institution*, 407 U.S. 355, 358 (1971) [custodial confinement without treatment raises "substantial constitutional questions"] so is the *Shelton, Jackson, McNeil* line of cases applicable to the situation of the 46 children confronting the district court in this case.

In *McNeil* and *Jackson, supra*, this Court found that the necessary result of the unconstitutional confinement in those cases was release of the individuals involved. However, in this case, according to the district court's order, it is up to the state to decide how it is going to proceed with each of these children. The Court simply stated that there was one option that they didn't have–continued confinement of the 46 children *in institutions*.

Specifically, the court restricted its initial, preliminary relief[109] to steps which appeared essential to halt the harm and protect these children from further harm–*i.e.*, without making unreasonable demands on the state, but making its intent clear–by directing the state to "proceed as expeditiously as is *reasonably possible* (1) to provide necessary physical resources and personnel for whatever non-hospital facilities are deemed *by them* to be most appropriate for these children, and (2) to place these children in such non-

[109] The district court explicitly retained jurisdiction of the case, and anticipated clarifying its orders. 412 F.Supp. at 140.

hospital facilities as soon as *reasonably appropriate.*"[110] (emphasis added.)

The language of the court indicates that the state itself would be making determinations in fashioning the nature and scope of relief. The district court did not (nor does this Court) have to reach the issue of whether the retention of these 46 children by the state in non-institutional settings was constitutionally permissible.

Just as clearly and as reasonably, the Court's order that "the defendants shall spend such money of the State of Georgia as is reasonably necessary to provide such non-hospital facilities and personnel and to place these children in such non-hospital facilities"[111] is not barred by the Eleventh Amendment. This portion of the Court's order involves injunctive/prospective relief. As in *Ex parte Young*, 209 U.S. 123 (1908), state officials here were enjoined to form their future conduct to the requirement of the Fourteenth Amendment.

This Court has specifically recognized that injunctive relief may impose a heavy financial burden to the state:

> State officials, in order to shape their official conduct to the mandate of the Court's decrees, would more likely have to spend money from the state's treasury than if they had been left free to pursue their previous course of conduct. Such an ancillary effect on the state treasury is a permissible and often inevitable consequence of the principle announced in *Ex parte Young*.[112]

[110] Opinion of the District Court, 412 F.Supp. at 138.

[111] Opinion of the District Court, 412 F.Supp. at 139-40.

[112] *Edelman v. Jordan*, 415 U.S. 651, 668 (1974).

Thus the district court correctly concluded that the State could not continue to confine the 46 children in question in institutions relying on the reasoning in *Jackson*. Moreover, additional support for this result can be drawn from the Eighth Amendment prohibition against cruel and unusual punishment;[113] a "right to protection from harm;"[114] and a "right to treatment."[115]

[113] Without treatment, a mental hospital is no more than a prison. And a mentally ill person, confined without treatment, whether judged to have dangerous propensities or not, is being incarcerated as if his sickness were a crime. To so confine a person is unconstitutional. *Robinson v. California*, 370 U.S. 660, 666 (1962). And state authorities must, therefore, treat the patient or release him. *See also* n.37, *Ingraham v. Wright*, ____ U.S. ____, 97 S.Ct. 1401 (1977).

[114] In *New York Association of Retarded Citizens v. Rockefeller*, 357 F.Supp. 752, 764 (E.D. N.Y. 1973) (hereinafter *N.Y.A.R.C.*), the district court found release not an alternative for the mentally retarded inmates of the state institution in question because they were incapable of caring for themselves (functioning independently). However, despite this fact, the court found that, at the very least, the inmates possessed a basic "right to protection from harm" inflicted by conditions caused by or in the institution [similar to that of prisoners in criminal institutions].

[115] The constitutional right to treatment or release for involuntarily committed mental patients has received support over the last 17 years in numerous law review articles on the subject. *See e.g.*, Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); "Developments–Civil Commitment," *supra*; Note, "Rights of the Mentally Ill During Incarceration–the Developing Law," 25 U. Fla. L. Rev. 494 (1973); Comment, "*Wyatt v. Stickney* and the Right of Civilly Committed Mental Patients to Adequate Treatment," 86 Harv. L. Rev. 1282 (1973); Robitscher, "Right to Psychiatric Treatment: A Social-Legal Approach

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To paraphrase Justice Stewart [writing for the Court in *O'Connor v. Donaldson*, 422 U.S. 563, 574 (1975)

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to the Plight of the State Hospital Patient," 18 Vill. L. Rev. 11 (1972); Goodman, "Right to Treatment: The Responsibility of the Courts," 57 Georgetown L. J. 680 (1969); Katz, "The Right to Treatment–An Enchanting Legal Fiction," 36 U. Chi. L. Rev. 755 (1969); Note, "Civil Restraint, Mental Illness and the Right to Treatment," 77 Yale L. J. 87 (1967).

Further, the constitutional right to treatment or release for the mentally ill and the mentally retarded has been recognized by both federal and state courts. *See, e.g., Wyatt v. Stickney*, 325 F.Supp. 781 (M.D. Ala. 1971) and 344 F.Supp. 387, 390 (M.D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (class actions on behalf of the mentally ill and the mentally retarded); *Welsch v. Likins*, 373 F.Supp. 487 (D. Minn. 1974) (class action involving the mentally retarded); *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973); *Kesselbrenner v. Anonymous*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973); *Renelli v. Dept. of Mental Hygiene*, 340 N.Y.S.2d 498, ____ N.E.2d ____ (1973).

There is also a widening body of precedent holding that there is a constitutional right to treatment for persons committed under "non-penal" statutes for the purpose of care and treatment: (a) juvenile delinquents, *Nelson v. Heyne*, 355 F.Supp. 451, 459 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352, 360 (7th Cir. 1974); *Inmates of Boys Training School v. Affleck*, 346 F.Supp. 1354, 1364 (D. R.I. 1972); (b) "persons in need of supervision," *Martarella v. Kelley*, 349 F.Supp. 575, 585, 598-600 (S.D. N.Y. 1972), *enforced*, 359 F.Supp. 478 (S.D. N.Y. 1973); *M v. M*, 336 N.Y.S.2d 304, 71 Misc.2d 396 (Fam. Ct. 1970); *In re I*, 316 N.Y.S.2d 356 (Fam. Ct. 1970); (c) sexual offenders and defective delinquents, *Stachulak v. Coughlin*, 364 F.Supp. 686 (N.D. Ill. 1973); *Davy v. Sullivan*, 354 F.Supp. 1320, 1328-29 (M.D. Md. 1973) (three judge court); *Gomes v. Gaughn*, 471 F.2d 794, 800 (1st Cir. 1973); *Sas v. Maryland*, 334 F.2d 506 (4th Cir. 1964), *cert. denied*, 407 U.S. 355

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and citing *Jackson v. Indiana*, 406 U.S. 715 (1972) and *McNeil v. Director, Patuxent Institution*, 407 U.S. 245 (1972)]:

> [G]iven the [State's admissions as to inappropriate institutionalization] and resulting harm what was left as justification for keeping [these 46 children] in continued confinement? The fact that state law may have authorized confinement of the harmless mentally ill does not itself establish a constitutionally adequate purpose for the confinement. Nor [would it be] enough that [these children's] original confinement was founded on a constitutionally adequate basis, if in fact it was, because even if [their] involuntary confinement was initially permissible, it could not constitutionally continue after that basis no longer existed.

Clearly, the State cannot lawfully confine an individual thought to need treatment and justify that deprivation of liberty solely by providing some treat-

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(1972); *In re Maddox*, 351 Mich. 358, 88 N.W.2d 470 (1958); *Commonwealth v. Page*, 339 Mass. 313, 159 N.E.2d 82 (1959); *Director of Patuxent Institution v. Daniels*, 243 Md. 16, 221 A.2d 397 (1966); *Silvers v. People*, 22 Mich. App. 1, 176 N.W.2d 702 (1970); and (d) persons incompetent to stand trial, *United States v. Walker*, 335 F.Supp. 705, 708 (N.D. Cal. 1971); *United States v. Pardue*, 354 F.Supp. 1377, 1382 (D. Conn. 1973); *Nason v. Superintendent of Bridgewater State Hospital*, 253 Mass. 604, 612-13, 233 N.E.2d 908, 913-14 (1968); *Maatallah v. Warden, Nevada State Prison*, 86 Nev. 430, 420 P.2d 122 (1970).

ment. Our concepts of due process would not tolerate such a "trade-off."[116]

Both the child and society itself have a stake in the child's inappropriate confinement, for as the court below noted: "every minute of unnecessary or inappropriate confinement and detention of a child in a mental hospital is a deprivation of liberty which affects him adversely and from the harmful effects of which he may never recover." District Court Stay Denial, 412 F. Supp. 141, 145. As in *Morrissey v. Brewer,* 408 U.S. 471 at 484 (1971), society has a stake in whatever may be the chance of restoring [a child] to normal and useful life within the law.

In conclusion, it is important to bear in mind that faced with a situation where the state admitted that harm was being inflicted upon those 46 children, that the district court fashioned a very narrow, reasonable, preliminary order as a first step towards removing that harm.

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[116] *O'Connor v. Donaldson*, 422 U.S. 563, 589 (1975). Burger, C. J. concurring. *See also* Dr. Hodges, A. 42:

> Q: The point I am getting to, Doctor, and that I am trying to make to the court is that we are not keeping them caged over at the Central State Hospital, each in his own little place, with no stimulants or anything else, are we? We are providing *some sort of services?*
>
> A: Yes.
>
> Q: There is professional help provided?
>
> A: We make every effort for that to be so. *In some cases that is not possible.* (Emphasis added.)

CONCLUSION

For the foregoing reasons, the Appellees respectfully urge this Court to affirm the decision of the lower court.

Respectfully submitted,

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September, 1977

CERTIFICATE OF SERVICE

I, Gerald R. Tarutis, one of the attorneys for the Appellees herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that I have this day served opposing counsel in this action with three copies of the foregoing Brief of Appellees by depositing three copies of the same in the United States mail, with first class postage prepaid, addressed as follows:

R. Douglas Lackey
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This 22nd day of September, 1977.

GERALD R. TARUTIS
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